

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, October 11, 2002
8:58 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Public comment

MR. HACKBARTH: Our last order of business is a brief opportunity for public comments. Do we have any? Given the late hour, Jerry, please keep it brief.

MR. CONNOLLY: Yes, thank you, Glenn. My name is Jerry Connolly and I'm speaking to you today on behalf of Focus on Therapeutic Outcomes. I'm an independent consultant as well as having addressed the Commission before on behalf of the family physicians. But today I'm speaking on behalf of a national outcomes database in the rehab therapies that is 10-years-old and has over 1.4 million files in its very robust existence.

I want to direct my comments to the session before this. This was extremely valuable discussion of the overall program but what I want to talk about is the post-acute database that MedPAC is going to be developing. I think that it's very interesting to note that the outcome measures that you've talked about are really things like mortality, hospitalization, rehospitalization, when in fact in the post-acute spectrum, the assessment instruments that you have imbedded in the Medicare program are not part of that process really.

What they really measure in the MDS and the FIM and the OASIS are, or attempt to measure, are functional involvement and functional improvement. Really, if you want to pay for results, then there should be a developing a level of interest and a level of quantification of how much improvement there is in any given episode of care.

Not only that, but the way the system is built now, none of the instruments can talk to each other. The MDS is different from OASIS, is different from FIM, and there's nothing on the outpatient arena yet.

Because of this, and because we have reliability problems as one of the staff speakers was mentioning, then what we really need to do is create some sort of standardization within the post-acute spectrum. Now given the fact that there are political considerations, there are other considerations in terms of the MDS and the FIM and how they all got there, it doesn't look like standardization is on the short term horizon.

But in the absence of standardization, I would suggest that the answer lies in co-calibration. Co-calibration is something that can be done in the short term. It would allow MedPAC to look at the spectrum of care post-acutely. It would allow them to quantify the amount of improvement in any of those instances, in any of those sites of service. By virtue of the quantification of that improvement, in any of those given instruments by validating, co-calibrating those instruments, then you can create a value quotient.

So not only can you have the mortality, the hospitalization and that information, which I think is very important, but I think that what you need to do, and I would like MedPAC to consider, is taking one additional step of co-calibrating those existing instruments perhaps with another instrument in the outpatient arena and have that wealthy database going forward

that you seek and upon which you can build decisions and policies.

You can create an incentive-based payment system, not the least of which you can come up with, at least begin to come up with, a replacement for this \$1,500 therapy cap which continues to be extended, the moratorium continues to be extended.

So there's a number of features in terms of eliminating the unwarranted variation, coming to grips with what that episode of care is across the post-acute spectrum, and beginning to develop and alternative for the outpatient arena, the cap, and most importantly, being able to pay for results or come up with an incentive-based reimbursement in the post-acute care spectrum.

Thank you.

MS. McKUEN: Hello, I'm Erin McKuen from American Nurses Association. Very briefly, I just want to synergize what we've heard today about nursing home payments and quality of care. Nurses are acutely aware of a number of research projects completed in the last 24 months proving the relationship between nurse staffing and patient outcomes. I can, off the top of my head, think of a JCAHO report, a HRSA report, GAO report, IOM reports. When looking at patient outcomes in nursing homes, we're well aware of the relationship between R.N. hours and outcomes in nursing homes.

When looking at the quality of care in nursing homes and your quality indicators, we would strong urge you to look at nurse staffing. There is a report recently released by GAO stating that nurse staffing is more important than payment reimbursement in nursing homes in indicating outcomes, and that the two are not necessarily related. We encourage you to look at that.

Thank you.

MR. HACKBARTH: Thank you very much.